



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SECTION FOR LONG-TERM CARE REGULATION

CHANGE OF DIRECTOR OF NURSING IN A LONG-TERM CARE FACILITY

FACILITY INFORMATION	
Name of Facility	
Facility Address	City Zip
Skilled Nursing Facility <input type="checkbox"/> Intermediate Care Facility <input type="checkbox"/>	
DIRECTOR OF NURSING INFORMATION	
Name of the Director of Nursing	Effective Date of Change:
RN License Number	State Issued
<i>Please provide contact information other than the Long-Term Care Facility Telephone Number:</i>	
Telephone Number	E-Mail Address
Cell Phone Number	Other Emergency Number
Name of previous Director of Nursing:	
Last date of employment as Director of Nursing in this facility:	
AFFIDAVIT	
I attest by my signature that the statements contained in this form are true and correct to the best of my knowledge and belief. I further affirm that I have the express authority to sign this form on behalf of the operator.	
Authorized Signature	Date
Printed or Typed Name	Title of Signatory
<p>PLEASE RETURN THIS COMPLETED FORM BY MAIL, FAX OR E-MAIL:</p> <p>DEPARTMENT OF HEALTH AND SENIOR SERVICES SECTION FOR LONG-TERM CARE REGULATION LICENSURE UNIT 920 WILDWOOD DRIVE P.O. BOX 570 JEFFERSON CITY, MO 65102</p> <p>FAX # (573) 751-8493 E-MAIL ADDRESS: LTCAPPLICATION@HEALTH.MO.GOV</p>	